



GROUP CONTINUATION COVERAGE

CONSOLIDATED OMNIBUS BUDGET
RECONCILIATION ACT "COBRA"
PERS-HBD-85 (Rev 5/89)

PERS USE ONLY – DOCUMENT REFERENCE NUMBER

PUBLIC EMPLOYEES' RETIREMENT SYSTEM
Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240 FAX (916) 795-1277

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. PLEASE TYPE

PART A: ORIGINAL QUALIFYING EVENT AND DATES

1. Type of Action <input type="checkbox"/> NEW <input type="checkbox"/> Change	2. QUALIFYING EVENT <input type="checkbox"/> EMPLOYMENT SEPARATION/TIMEBASE REDUCTION <input type="checkbox"/> DIVORCE/LEGAL SEPARATION <input type="checkbox"/> CHILD CEASES TO BE A DEPENDENT <input type="checkbox"/> DEATH OF AN EMPLOYEE/RETIREE <input type="checkbox"/> DEPENDENT CONTINUATION – ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE	3. EVENT DATE 	4. COBRA ENROLLMENT PERIOD FROM 01 TO
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PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) SOCIAL SECURITY NUMBER NAME ADDRESS CITY, STATE, ZIP	6. SUBSCRIBER (EMPLOYEE/RETIREE) SOCIAL SECURITY NUMBER NAME ADDRESS CITY, STATE, ZIP
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PART D: DEPENDENT INFORMATION

Day Phone ()	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	A C C I D E N	LIST ALL PERSONS (including self) TO BE ENROLLED IN: (FIRST) (MI) (LAST)	DATE OF BIRTH			FAMILY RELATION SHIP
BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			MO.	DAY	YR	
PART C: CARRIER INFORMATION							SELF
7. NAME AND ADDRESS OF HEALTH PLAN							
PLAN CODE: _____ PREMIUM: \$ _____							
PHONE: _____							

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN	11. PERMITTING EVENT CODE	12. PERMITTING EVENT DATE	13. EFFECTIVE DATE OF CHANGE
10. PRIOR PLAN CODE			01

PART F: ELECTION CERTIFICATION

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

SIGNATURE OF COBRA ENROLLEE (SEE REVERSE FOR PRIVACY INFORMATION)

DATE SIGNED

PART G: AGENCY INFORMATION

15. AGENCY NAME _____ AGENCY CODE _____ UNIT CODE _____	16. HEALTH BENEFITS OFFICER'S SIGNATURE _____ PHONE () _____ DATE RECEIVED _____
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PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

INSTRUCTIONS FOR THE COMPLETION OF FORM HBD-85 (11/04)

- Part A: 1. Type of Action. Check "new" if this is a new enrollment.
Check "change" if family member is added, deleted, or for plan changes.
2. Check applicable original qualifying event.
3. Provide original event date (separation, date of divorce, etc.).
4. Original COBRA enrollment period. Examples:
 Separation from employment 4-15-89 (Perm. Event) FROM 6-1-89 TO 11-30-90
 Child attains age 23 on 6-15-89 (Perm. Event) FROM 7-1-89 TO 6-30-92
- Part B. 5. Please provide all requested information.
6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in Box 6.
- Part C. 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the open enrollment period of if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, phone number, plan code, and premium can be found in the annual "Health Plan Decision Guide" which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.
- Part D. 8. List all family members to be enrolled, including self.
 Action Code: Use "A" to indicate which person is being added (or newly enrolled).
 Use "D" to indicate individual is being deleted from an existing COBRA enrollment
 An Action Code is not required when changing carriers.
 IMPORTANT: The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).
- Part E. 9-10. Name and plan code of prior health plan, if COBRA coverage is being changed
10-13. To be completed by the Health Benefits Officer.
- Part F. 14. Signature of COBRA enrollee and date signed.
- Part G. 15-16. To be completed by the (former) employing agency. For former dependents of retirees, PERS is the "employing agency."

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.